SAMHSA-HRSA
CENTER for INTEGRATED
HEALTH SOLUTIONS

Tips from the Graduating Class

Cohort V Grantees:
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ARLINGTON COUNTY CSB A NEW LEASE ON LIFE PROJECT

COHORT 5

TIPS FROM THE GRADUATING CLASS

GENERAL OVERVIEW

General information:

- Arlington County CSB services are provided by the Department of Human Services to individuals with mental health, intellectual disabilities and substance use disorders
- Number of Behavioral Health Division (BHD) staff-165
- 6,343 clients served by all CSB programs
- 1,078 unique clients seen at our onsite primary care clinic
- IPAT level- Level 4

Primary care provision:

- Neighborhood Health is our FQHC primary care partner.
- Primary care services are provided 2 days per week
- Staffing includes a family medical practitioner, nurse coordinator and medical assistance. Lab Services are available on site and discounted pharmacy and PAP medications are available to the FQHC and other costs provided by partner.
- The grant also covers a Peer Health Navigator, Eligibility Specialist, and Project Assistant to assist with data collection.

ACCOMPLISHMENTS

In a recent satisfaction survey, 94% of clients served identified the CSB/FQHC as their primary source of care, citing "going without" or using the ED as the only viable options if this service did not exist.

Success Stores:

"Has anyone ever told you that you have a heart murmur?" That's how one client's journey to heart valve replacement began.

- Our client was sitting in the lobby at the Center one day and saw the Clinic (Neighborhood Health) poster encouraging clients to have annual physicals and he made the decision right then to talk with his case manager about a referral to the clinic—he had not seen a primary care physician in recent years and was pleased by his experience in the clinic. At that first appointment, the PCP asked him about the heart murmur. In short order, a referral to a cardiologist was made for more extensive testing and in 2014, he underwent successful valve replacement surgery. Our client is making a wonderful recovery and said, "The doctor is a competent and caring physician who caught my murmur and got me the help I needed. She has a good staff and they helped me too".
- Our client told us that he wants others to go in for a physical—even if they feel fine. "Preventative care is so important. If your car breaks down, you go see a mechanic. If your tooth hurts you go see a dentist. It should be the same with your physical health, but don't wait until something hurts. Get a physical, it's the smart thing to do!"
- "DC came to us as a new patient in December 2015. At the time, he had multiple chronic health conditions--uncontrolled hypertension, poorly controlled type 2 diabetes, and dyslipidemia. He had been hospitalized on multiple occasions for hyperglycemia and stated he was unable to afford insulin due to cost. Through our pharmacy assistance program, he was able to receive all his medications. We counseled him extensively on lifestyle changes including healthy diet, proper exercise, and medication compliance. Since following these recommendations, his blood pressure, diabetes, and cholesterol are now stable and well controlled. During a recent visit, he described generally feeling well and shared with us that he had been promoted to head cashier at his work and is enjoying increased responsibilities."

ACCOMPLISHMENTS

- Hiring a Peer Health Navigator through the grant in integrated settings has been a key strategy to reducing both personal and institutional stigma.
- The successful integration of this position had led the County to create and 4 permanent peer positions across the CSB.
- The integration of health services has led to a cultural transformation with respect to health and wellness assessments and intervention, including more rigorous training on tobacco cessation, MI, chronic disease self management, along with workflow and EHR modifications to better track outcomes.
- Cross-training on EHRs in CSB and FQHC.
- Training for FQHC staff on Mental Health First Aid

IF I KNEW THEN WHAT I KNOW NOW…

What is one piece of start-up advice thinking about it you would give to cohort VIII or future grantees? What would you recommend grantees NOT do? What is one recommendation to newer grantees regarding sustainability?

- Begin planning and conceptualizing sustainability early. Think about value added of each activity, along with cost and impact.
- Develop a plan that articulates goals, defines partner relationships and create a shared vision with partners and community leaders.
- Conduct upfront training for FQHC staff on behavioral health issues.
- Continue to evaluate expenses throughout the grant period, looking for ways to reallocate resources to support grant operations. Maintain rigorous financial reporting expectations of FQHC.
- Choose an external evaluator that is available and hands-on and can identify data problems and assist with problem solving farther upstream.
- Find champions. Locate and encourage organizations and interest groups that benefit from the project's activities or who are interested in the target groups being served.
- Work closely with SAMHSA, reach out to other funders on behalf of an initiative, jointly develop an exit strategy, open doors that might not be accessible to grantees, and help grantees to identify and pursue alternative resources.

MOVING FORWARD

- What will change about your model/services?
  - Our partnership agreement with Neighborhood Health might change as the County requires us going through a bidding process.
  - We will not be expanding our services but might look at having more clinic days down the road.
  - We are continuing the Peer Health Navigator and adding 4 Peer Specialists trained in WHAM in various other programs. The Evaluator, Project Assistant and eligibility position will be absorbed by the County.
  - We plan to expand the role of Peer Health Navigator to serve more as a liaison between the FQHC and the Behavioral Health staff. Clients feel more comfortable discussing health issues with the Peer Health Navigator than with their case manager or the doctor.
- Describe biggest challenge and efforts to sustain services:
  - Uncertainty regarding Primary Care provider as County requires a bidding process
  - Primary Care Clinic available only 2 days a week .
  - Complex medical needs of the clients so clinic can only accommodate 12-14 clients/day
  - Specialty Care-Obtaining local specialty care continues to be a challenge for patients who are uninsured or underinsured.
  - Lack of Medicaid expansion in Virginia leads to high percentage of uninsured individuals, limiting service reimbursement mechanisms.

Tips from the Graduating Class

Jeanie Tse MD, Project Director, ICL

Cohort V

PBHCI Regional Meeting July 19, 2016

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General Overview

- ICL is a not-for-profit behavioral health agency providing a continuum of housing and treatment services to about 10,000 clients throughout NYC
- PBHCI was piloted in two behavioral health clinics and one Personal Recovery Oriented Service (PROS) rehabilitation program in east Brooklyn
  - About 70 staff members
  - About 1000 adult clients
    - >50% Black/African-American, >30% Hispanic/Latino
    - >70% schizophrenia or schizoaffective disorder
  - IPAT level 6 (with continued challenges and change)
- Primary care provision
  - Initially subcontracted PCP from FQHC, then hired PCP outright. Currently moving towards partnership with new FQHC
  - The 3 programs share a 40h/wk PCP
  - Nursing health monitoring, medical technician and peer health coaching also provided onsite.

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Accomplishments

- Reduction in ER and hospital utilization, with specific changes on these measures for groups experiencing health disparities
- Our strength lies in being able to address the impact of trauma on a person's engagement with health services

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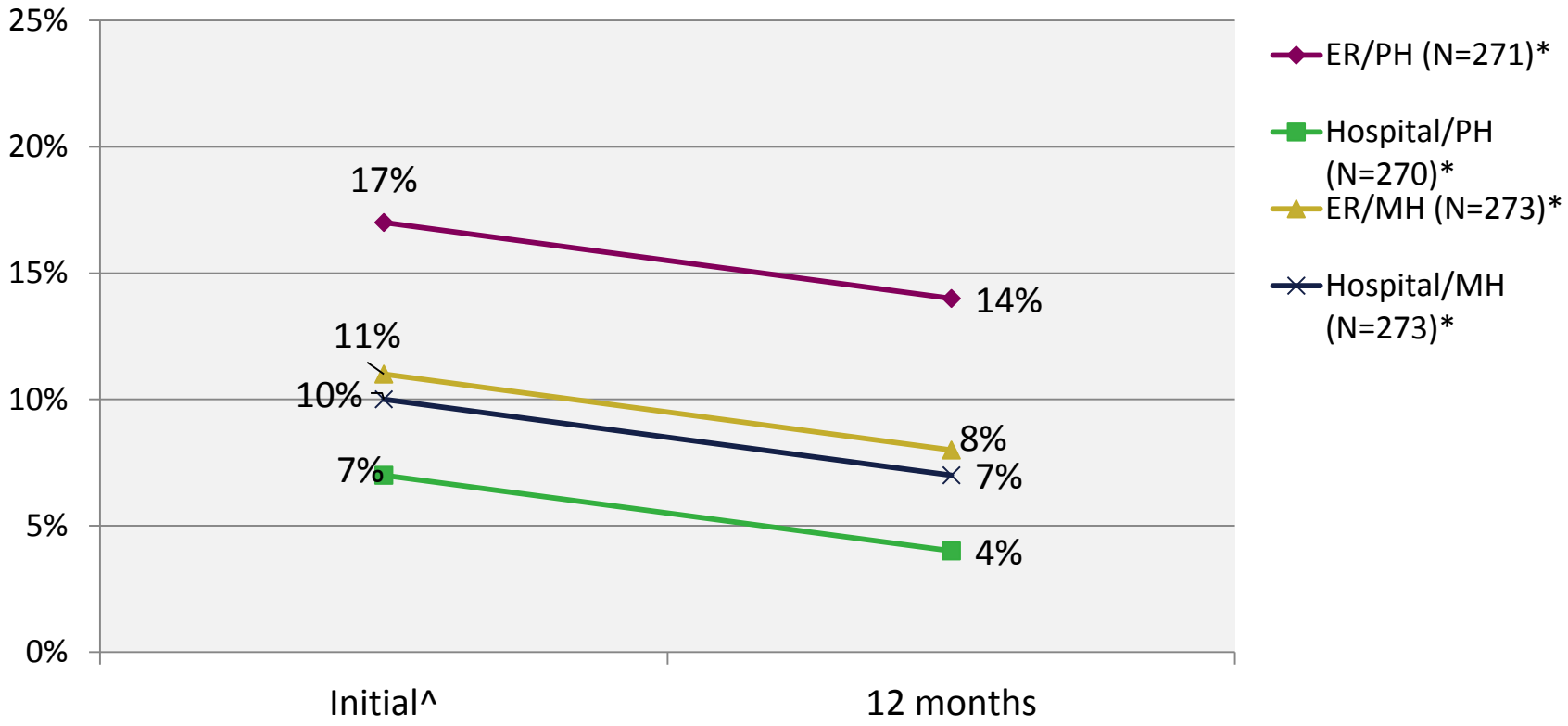
People get better with us.

ER/Hospital admissions for physical health and mental health reasons (all, $p<.05$)



^Initial defined as first HLQ from project start date (February 2013). Therefore sample includes responses captured upon and after program admission

⁺Includes open/closed cases

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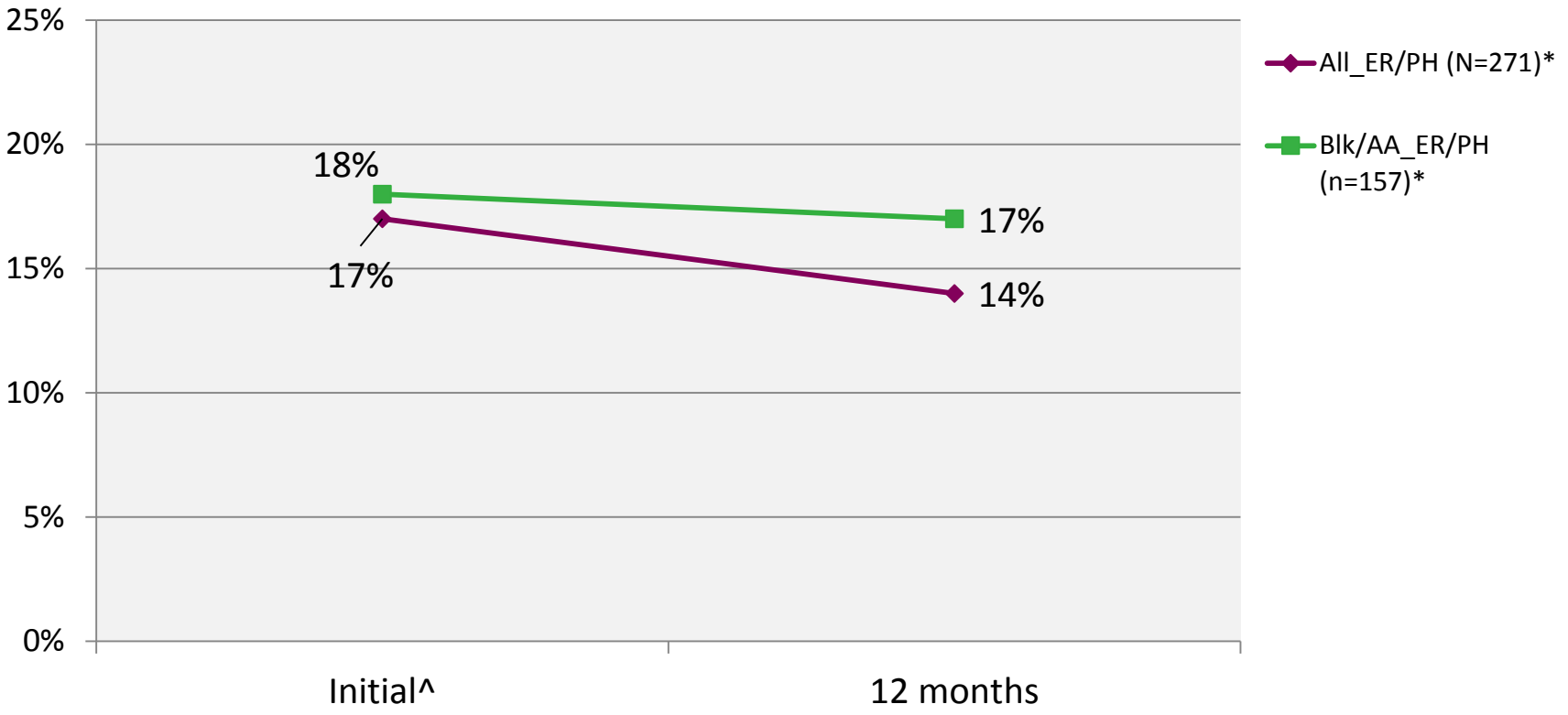
People get better with us.

ER visits for physical health reasons by cohort

(all, $p<.05$)



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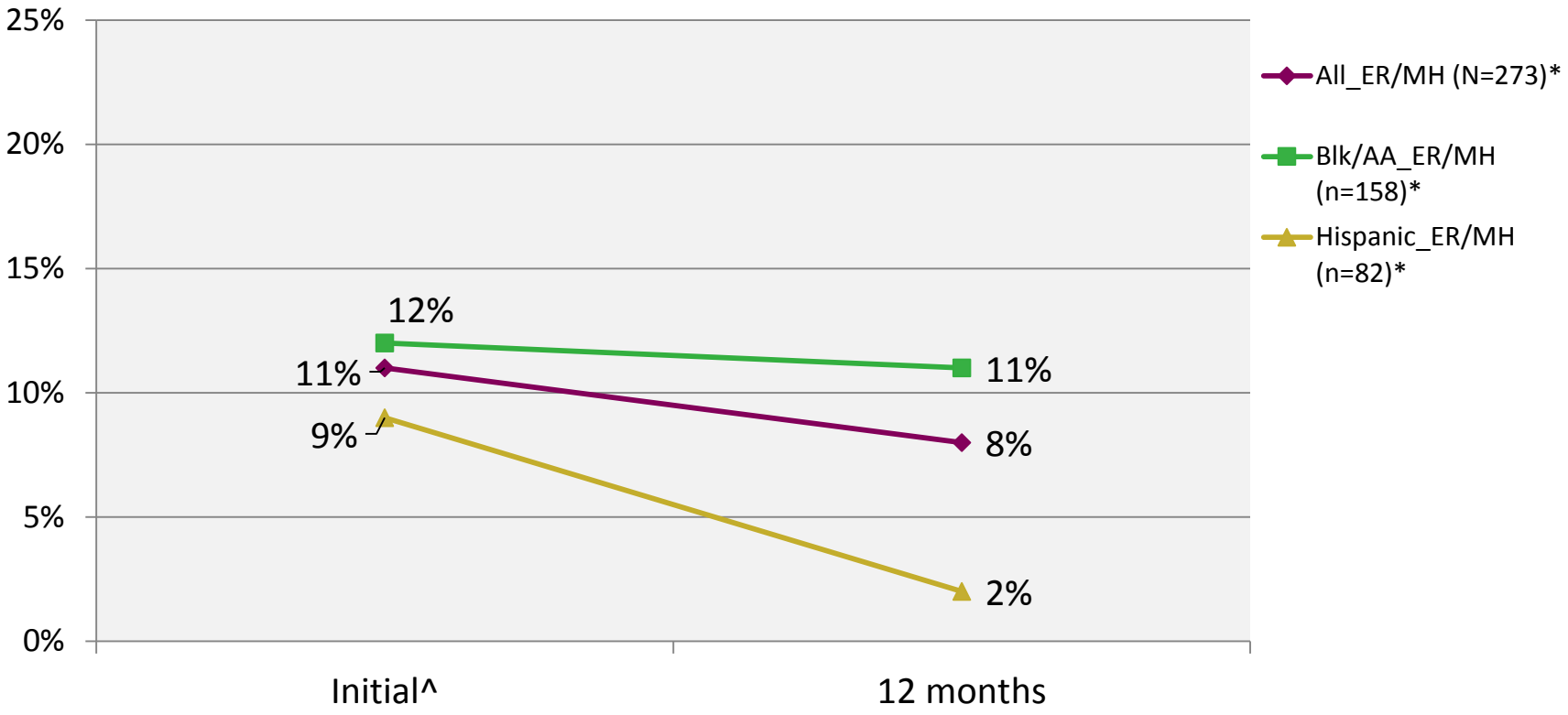
People get better with us.

ER visits for mental health reasons by cohort

(all, $p<.05$)



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If I Knew Then What I Know Now…

- DO: measure service utilization, looking for evidence that you can save systems costs to justify the value of what you do
- DO NOT: use a sustainability model that relies too heavily on PCP productivity
- DO: Advocate for systems change to support sustainability, but have a good contingency plan in place

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Moving Forward

- Partnership with Community Healthcare Network FQHC
  - Full range of primary and specialty care services onsite
  - Ability to serve people in the community who may not have a primary behavioral health diagnosis, but who may experience other challenges to health care access (i.e. trauma)
  - Services we want:
    - Dental
    - Women's health
    - Ophthalmology
    - Colonoscopy
- Fee-for-service rather than value-based reimbursement presents a continuing challenging to sustainability

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AtlantiCare

Taking You Well Into The Future

COMPREHENSIVE WELLNESS CENTER

Atlantic City, New Jersey

Cohort 5

- Sile Keane, Director
- Kelly Turner, Program Manager

The Comprehensive Wellness Center

Overview:

- We are an Outpatient Behavioral Health program located at the AtlantiCare Health Plex. We serve the severe and persistently mentally ill (SMI) population of Atlantic County, with a priority focus on those with chronic health conditions.
- Our staff consists of Psychiatrists, Medical Doctors (MD), Advanced Practicing Nurse (APN) Therapists, Medical Assistant (MA), a Care Manager, a Peer Specialist, and Client Services Representatives
- We have served 699 unduplicated clients as of 6/30/16.
- According to the IPAT, our program is at an integrated level of 5 due to not having one integrated electronic health record that has incorporated one integrated treatment plan.

Primary Care Services

- The Comprehensive Wellness Center collaborates with our Specialty Care Center by purchasing medical care provision for our clients.
- We have 26 hours a week of onsite primary care, an additional 8 hours of health coaching, as well a 24 hour on call service.
- Since we are conveniently located at the AtlantiCare Health Plex, our clients have access to our laboratory, pharmacy, and financial services. Being at this location also means we are only a few blocks from the hospital and many other community services such as the Atlantic County Board of Social Services.

Accomplishments

- Due to all the team's hard work, we are able to be sustainable in the primary and behavioral health services we offer. Medical reimbursement has given us the opportunity to continue the work we do by supporting those services financially.
- The CWC team and many of the other behavioral programs in our service line have a foundation of integration and the CWC team has developed critical thinking skills and language related to the medical field and integration.
- The CWC offers continued medical care to those clients who become disengaged from behavioral health or those who no longer need behavioral health care. This has benefited those clients who need to re-engage in behavioral health services.

If we only knew…

- For behavioral health organizations who try to integrate medical care, learning all the many facets of actual medical care, billing, insurances, etc… was very time consuming and if we had know sooner some of these processes, we would have started earning money sooner to support program.
- Behavioral health staff felt “culture shock” to the concept of integration and providing primary care services.
- The team recognized the need to adjust how they “practice” to overcome clients resistance to integration (ie- sick call, told to come to office, goes to ER instead).

The Future of the CWC

- We will continue to collaborate and purchase our primary care services from the Specialty Care Center with a focus on increasing medical care to those within our whole service line.
- Unfortunately, we are unable to sustain the Care Manger and Peer Specialist position at the CWC. These two positions will be rolled into the behavioral health home that is currently being developed.

Arlington County CSB (VA)
AtlantiCare (NJ)
ICL (NY)
NY Psychotherapy and Counseling Center
FMRS (WV)
Lincoln Medical and MH Center (NY)